Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRATIVE HEALTH AND MEDICAL
PO BOX 9973
THE WOODLANDS TX 77387

Carrier's Austin Representative Box
Box Number 21

Respondent Name
HOUSTON ISD

MFDR Date Received
MARCH 14, 2013

MFDR Tracking Number
M4-13-1807-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are filing for MDR at this time, regarding our 03-19-2012 electrodiagnostic service, due to the fact that the insurance carrier did not adjudicate the 'Request for Reconsideration' as required by current rule. The reconsideration was faxed on 02-04-13 via verified carrier fax number with no response."

Amount in Dispute: $3,575.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the Medical Dispute Resolution DWC 60 concerning claimant Veronica Carrizales from Integrative Health & Medical for date of service 03/19/12. Based on the submitted documentation a recommendation is being made in the amount of $1409.70. A copy of the explanation of benefits has been included for review."

Response Submitted by: IMO, 4100 Medway Road, Ste. 1145, Carrollton, TX 75007

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	CPT Codes 99202, 95861, 95903, 95904	$3,125.00	$0.00
March 19, 2012	CPT Code 95904 (2 Units)	$450.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §137.100 sets out the procedures for health care under the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - W1 – Workers Compensation jurisdictional fee schedule adjustment.
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.

Issues

1. Did the respondent uphold the original denial of untimely filing and issue payment for the services in dispute?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. Review of the insurance carrier's response to the request for medical fee dispute resolution, the Division finds that the respondent did not uphold the denial of 29 – "The time limit for filing has expired." The requestor was contacted on September 17, 2013 in reference to the payment made by the carrier. The contact, Kirt Repp, said the carrier did not pay 2 units of CPT Code 95904 and there was still $183.68 due. Review of the EOB submitted by the respondent shows the 2 units of CPT Code 95904 were denied as 50 – These services are non-covered services because this is not deemed a medical necessity by the payer"; however all other services have been reimbursed.
2. 28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." In accordance with 28 Texas Administrative Code §133.307(f)(d)(B) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. In accordance with 28 Texas Administrative Code §137.100, review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		October 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.